Town of Dumfries
Council Meeting

Meeting Date: April 16, 2013

Agenda Item#: VI – E

AGENDA ITEM FORM

TYPE OF AGENDA ITEM:
- ☐ CONSENT AGENDA
- ☐ PRESENTATION
- ☐ ACTION ITEM
- ☐ TOWN MANAGER & STAFF COMMENTS
- ☐ PUBLIC HEARING
  - ☐ Duly Advertised

PURPOSE OF ITEM:
- ☐ INFORMATION ONLY
- ☑ DISCUSSION ONLY
- ☐ DISCUSSION AND/OR DECISION
  - ☐ Introduction ☐ Resolution
  - ☐ Ordinance ☐ Grant/MOU
  - ☐ By Motion ☐ Bylaws
  - ☐ Certificate

PRESENTER: Daniel E. Taber **PRESENTER TITLE:** Town Manager

AGENDA ITEM:

Health Insurance Benefits for Employees

BACKGROUND / SUMMARY:

Certain Council Members have expressed an interest In Improving Health Insurance Benefits for employees. Efforts have been made to identify health insurance providers that may offer lower rates to Town Employees. Without a significant decrease in coverage, no providers have been located that can offer similar coverage at a lower rate than that already being paid. If fact, the costs for similar coverage would increase using other providers. The Town Manager recommends that the Town Council approve a policy that allows the Town to provide the amount of the Town's current cost of health insurance for employees directly to currently covered employees who request this with the understanding that they will use this toward obtaining health insurance on their own. In many cases, employees would be able to obtain equal or better health insurance coverage at lower out of pocket costs.

ATTACHMENTS:

Current Coverage Information

REQUESTED ACTION: **X** NO ACTION REQUESTED

FOR MORE INFORMATION, CONTACT: Name: Dan Taber

Phone#: (703) 221-3400 X113 E-mail: dtaber@dumfriesva.gov

FOR USE DURING MEETING **VOTE:** ☐ PASSED ☐ NOT PASSED

Y	N		Y	N		Y	N	
☐	☐	Brewer	☐	☐	Foreman	☐	☐	Forrester
☐	☐	Reynolds	☐	☐	Toney	☐	☐	Washington
☐	☐	Wood						

The Local Choice Health Benefits Program

Town Of Dumfries

Proposed Rates Effective from July 1, 2012 through June 30, 2013

	Single	Dual	Family
ACTIVE EMPLOYEES			
Key Advantage Expanded	$571	$1,056	$1,542
* Key Advantage 250	$529	$979	$1,428
Key Advantage 500	$490	$907	$1,323
Key Advantage 1000	$461	$853	$1,245
High Deductible Health Plan	$406	$751	$1,096

*** Benefit Plans Currently Offered**

Please note that accounts with 25 or less employees can choose only one benefit plan.

Coverage under The Local Choice Key Advantage and HDHP contracts is for:

- Active Employees and their Dependents
- Retirees not eligible for Medicare and their Dependents not eligible for Medicare, and/or
- Dependents of Medicare eligible Retirees who are not Medicare eligible.

If coverage is offered to Medicare eligible retirees and their Medicare eligible Dependents, it must be obtained through one of our Medicare Supplemental contracts which require participation in both Parts A and B of Medicare to receive maximum benefits.

The Local Choice Health Benefits Program

Town Of Dumfries

Proposed Rates Effective from
July 1, 2013 through June 30, 2014

	Single	Dual	Family
ACTIVE EMPLOYEES			
Key Advantage Expanded	$620	$1,147	$1,674
* Key Advantage 250	$575	$1,064	$1,553
Key Advantage 500	$530	$981	$1,431
Key Advantage 1000	$500	$925	$1,350
High Deductible Health Plan	$440	$814	$1,188
RETIREES NOT ELIGIBLE FOR MEDICARE			
Key Advantage Expanded	$620	$1,147	$1,674
* Key Advantage 250	$575	$1,064	$1,553
Key Advantage 500	$530	$981	$1,431
Key Advantage 1000	$500	$925	$1,350
High Deductible Health Plan	$440	$814	$1,188
RETIREES WITH MEDICARE			
Advantage 65	$160		
* Advantage 65 and Dental/Vision	$190		

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The Local Choice 2013 Comparison of Statewide Plans

	Key Advantage Expanded	Key Advantage 250
Plan year deductible (Key Advantage: applies to certain medical services as indicated on chart) (HDHP: applies to medical, behavioral health, and prescription drug services)	**In-Network:** One Person: $100 Two People: *See Family* Family: $200 **Out-of-Network:** $200 / *See Family* / $400	**In-Network:** One Person: $250 Two People: *See Family* Family: $500 **Out-of-Network:** $500 / *See Family* / $1,000
Plan Year Out-of-pocket expense limit	**In-Network:** One Person: $1,000 Two People: *See Family* Family: $2,000 **Out-of-Network:** $2,000 / *See Family* / $4,000	**In-Network:** One Person: $2,000 Two People: *See Family* Family: $4,000 **Out-of-Network:** $4,000 / *See Family* / $8,000
Out-of-network benefits	Yes. Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services. Copayments and coinsurance for routine vision, outpatient prescription drugs and dental services will still apply.	Yes. Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services. Copayments and coinsurance for routine vision, outpatient prescription drugs and dental services will still apply.
Medical care when traveling	Included	Included
Lifetime maximum	Unlimited	Unlimited
Covered Services	**In-Network You Pay**	**In-Network You Pay**
Ambulance travel	20% coinsurance after deductible	20% coinsurance after deductible
Autism Spectrum Disorder 2 years to 6 years $35,000 Annual Limit (Applies to Applied Behavioral Analysis only)	Copayment/coinsurance determined by service received	Copayment/coinsurance determined by service received
Behavioral health and EAP *Inpatient treatment* • Facility services • Professional provider services *Outpatient professional provider visits*	 $200 copayment per stay $0 $15 copayment	 $300 copayment per stay $0 $20 copayment
Employee Assistance Program (EAP) 4 visits per incident (per rolling 12 months)	$0	$0
Dental *Dental plan year deductible* *Plan year maximum (except Orthodontics)* *Diagnostic and preventive services* *Basic dental care* *Major dental care* *Orthodontic services (includes adult ortho)*	One Person: $25 Two People: $50 Family: $75 $1,500 $0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with $1,500 lifetime maximum	One Person: $25 Two People: $50 Family: $75 $1,200 $0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with $1,200 lifetime maximum
Diabetic Education	$0	$0
Diabetic Equipment	20% coinsurance after deductible	20% coinsurance after deductible
Diabetic Supplies - see Outpatient prescription drugs		
Diagnostic tests and x-rays (for specific conditions or diseases at a doctor's office, emergency room or outpatient hospital department)	10% coinsurance, no deductible	10% coinsurance after deductible
Doctor visits – on an outpatient basis *Primary care physicians* *Specialty care providers*	 $15 copayment $25 copayment	 $20 copayment $35 copayment
Early Intervention Services	Copayment/coinsurance determined by service received	Copayment/coinsurance determined by service received

The Local Choice 2013 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
Emergency room visits		
Facility services	$100 copayment per visit (waived if admitted to hospital)	$150 copayment per visit (waived if admitted to hospital)
Professional provider services		
• Primary care physicians	$15 copayment	$20 copayment
• Specialty care providers	$25 copayment	$35 copayment
Diagnostic tests and x-rays	10% coinsurance, no deductible	10% coinsurance after deductible
Home health services (90 visit plan year limit per member)	$0	$0
Home private duty nurse's services	20% coinsurance after deductible	20% coinsurance after deductible
Hospice care services	$0	$0
Hospital services		
Inpatient treatment:		
• Facility services	$200 copayment per stay	$300 copayment per stay
• Professional provider services		
– Primary care physicians	$0	$0
– Specialty care providers	$0	$0
Outpatient treatment		
• Facility services	$100 copayment	$150 copayment
• Professional provider services		
– Primary care physicians	$15 copayment	$20 copayment
– Specialty care providers	$25 copayment	$35 copayment
• Diagnostic tests and x-rays	10% coinsurance, no deductible	10% coinsurance after deductible
Infusion services		
Facility services	10% coinsurance after deductible	10% coinsurance after deductible
Professional provider services	10% coinsurance after deductible	10% coinsurance after deductible
Home services	10% coinsurance after deductible	10% coinsurance after deductible
Infusion medications -		
• Outpatient settings	10% coinsurance after deductible	10% coinsurance after deductible
• Home settings	10% coinsurance after deductible	10% coinsurance after deductible
Maternity		
Professional provider services (prenatal & postnatal care)		
• Primary care physicians	$15 copayment	$20 copayment
• Specialty care providers	$25 copayment	$35 copayment
	If your doctor submits one bill for delivery, prenatal and postnatal care services, there is no copayment required for physician care. If your doctor bills for these services separately, your payment responsibility will be determined by the services received.	
Delivery		
• Primary care physicians	$0	$0
• Specialty care providers	$0	$0
Hospital services for delivery (delivery room, anesthesia, routine nursing care for newborn)	$200 copayment per stay*	$300 copayment per stay*
Outpatient diagnostic tests	10% coinsurance, no deductible	10% coinsurance after deductible
Medical equipment, appliances, formulas, prosthetics and supplies	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient prescription drugs - mandatory generic		
*Retail up to 34-day supply**	Tier 1 - $10 copayment	Tier 1 - $10 copayment
*You may purchase up to a 90-day supply at a retail pharmacy by paying multiple copayments, or the coinsurance after the deductible	Tier 2 - $20 copayment Tier 3 - $35 copayment	Tier 2 - $20 copayment Tier 3 - $35 copayment
Home Delivery Services (Mail Order) Covered drugs for up to a 90-day supply	Tier 1 - $20 copayment Tier 2 - $40 copayment Tier 3 - $70 copayment	Tier 1 - $20 copayment Tier 2 - $40 copayment Tier 3 - $70 copayment
Diabetic Supplies	20% coinsurance, no deductible	20% coinsurance, no deductible

**This plan will waive the hospital copayment if the member enrolls in the maternity management pre-natal program within the first trimester of pregnancy, has a dental cleaning during pregnancy and satisfactorily completes the program.*

***You may select a frame greater than the covered allowance and receive a 20% discount for any additional cost over the allowance.*

The Local Choice 2013 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
Routine vision - Blue View Vision Network (once every 12 months)		
Routine eye exam	$25 copayment	$35 copayment
Eyeglass lenses	$20 copayment	$20 copayment
Eyeglass frames	Up to $100 retail allowance**	Up to $100 retail allowance**
Contact lenses (in lieu of eyeglass lenses)		
• Elective	Up to $100 retail allowance	Up to $100 retail allowance
• Non-Elective	Up to $250 retail allowance	Up to $250 retail allowance
Upgrade eyeglass lenses (available for additional cost)		
• UV coating, tints, standard scratch-resistant	$15	$15
• Standard polycarbonate	$40	$40
• Standard progressive	$65	$65
• Standard anti-reflective	$45	$45
• Other add-ons	20% off retail	20% off retail
Shots – allergy & therapeutic injections (at doctor's office, emergency room or outpatient hospital department)	10% coinsurance, no deductible	10% coinsurance after deductible
Skilled nursing facility stays (180-day per stay limit per member)		
Facility services	$0	$0
Professional provider services	$0	$0
Spinal manipulations and other manual medical interventions (30 visits per plan year limit per member)		
Primary care physicians	$15 copayment	$20 copayment
Specialty care providers	$25 copayment	$35 copayment
Surgery – see Hospital services		
Therapy services *Cardiac Rehabilitation therapy, Chemotherapy, Radiation therapy, Respiratory therapy Occupational therapy, Physical therapy, and Speech therapy*		
Facility services	10% coinsurance after deductible	10% coinsurance after deductible
Professional provider services		
• Primary care physicians	10% coinsurance after deductible	10% coinsurance after deductible
• Specialty care providers	10% coinsurance after deductible	10% coinsurance after deductible
Wellness services *Well child (office visits at specified intervals through age 6)* • Primary care physicians; • Specialty care providers; • Immunizations and screening tests	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
Routine wellness – age 7 & older • Annual check-up visit (one per plan year) – Primary care physicians – Specialty care providers – Immunizations, lab and x-ray services	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
• Routine screenings, immunizations, lab and x-ray services (outside of Annual check-up visit)	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
Preventive care (one of each per plan year) • Gynecological exam • Pap test • Mammography screening • Prostate exam (digital rectal exam) • Prostate specific antigen test • Colorectal cancer screenings	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible